ANNEXURE V

F M C NETWORK UAE

P. O. BOX: 50430, DUBAI, Tel – 04 3871900, Fax – 04 3977842
Email – approval@fmchealthcare.ae Helpline Number: 600-565691

Medical Expenses Claim form

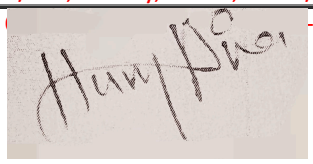
Date: 27-Nov-2024
Clinic Name: CITICARE MEDICAL CENTER LLC Emirates: 784-1996-5101490-6
Card Holder's Name: ABDUL RAZZAQ SIDDIQUI Age: 28Y - 7M - 21D Sex: Male
Card Holder's Tel No: Mobile No: 055-758-9660
Ins Card No: I019-010-119490895-01 Valid Upto: 7/6/2025
Company Name: FMC Standard Network Employee No: _____ Nationality: Indian

Clinical Details: Temp36 B.P.100 Pulse. 75
Signs & Symptoms: risk of fall
Date of Onset Illness : ○ Emergency ○ Work related ○ New visit ○ Follov
Diagnosis: A09 - Infectious gastroenteritis and colitis, unspecified, R50.9 - Fever, unspecified, R11.10 - Vomiting, unspecified, F
Unspecified abdominal pain, E86.0 - Dehydration

Management plan (Services inside the clinic including injections and investigations)

0195-107704-0801, CEFTRIAXONE-TABUK IV , Pharmacy,0002-116601-1001, (METRONIDAZOLE : 500 MG/100ML) SOLUTION F
, Pharmacy,0005-136504-1021, SCOPINAL , Pharmacy,0102-111908-1001, SODIUM CHLORIDE B.P. , Pharmacy,96365, IV INFUS
THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR , Co.Pay,96372, THER/PROPH/DIAG INJ SC/IM , Co.Pay,96374, THER/PROPH/DIAG IN
Co.Pay,96360, HYDRATION IV INFUSION INIT , Co.Pay,9, Consultation Gp , General
SODIUM) : 40 MG) POWDER FOR INJECTION , Pharmacy

Doctor's Name: Humaira signature with seal:



Diagnostic Procedures referred outside:

I hereby authorize the physician, Hospital or pharmacy to file a claim for medical services on my behalf and I confirm that the mentioned examination/Investigation/therapy is given to me by the doctor. I hereby authorize any Clinic, Physician, Pharmacy person who has provided medical services to me to furnish any and all information with regard to any medical history, medica medical services and copies of all medical and Clinic records.

Signature of the Patient

Date 27-Nov-2024

Pharmaceuticals (to be filled by treating doctor only)

Medicine	Dose	Duration	Quan
(CAFFEINE : 65 MG) (PARACETAMOL : 500 MG) CAPLETS	CAPLETS (24S, BOX)	6	12
(CEFIXIME : 400 MG) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (6S, BLISTER PACK)	7	7
(METRONIDAZOLE : 500 MG FILM COATED TABLETS	FILM COATED TABLETS (20S, BLISTER PACK	7	14

Medicine	Dose	Duration	Quant
(ORAL REHYDRATION SALTS (O.R.S.) : N/A) POWDER FOR SOLUTION	POWDER FOR SOLUTION (28.5G X 10, SACHET)	5	5
(SPORE OF BACILLUS CLAUSI : 2 BILLION) CAPSULES (HARD GELATIN)	CAPSULES (HARD GELATIN) (12S, BLISTER)	7	21